BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the First Amended Accusation Against:	)	
ISIDORE KOFI-BREKYI KWAW, M.D.	)	Case No. 800-2014-010068
Physician's and Surgeon's Certificate No. G66583	)	
Respondent	)	

DECISION

The attached Stipulated Settlement and Disciplinary Order is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on August 24, 2018.

IT IS SO ORDERED: July 25, 2018.

MEDICAL BOARD OF CALIFORNIA

Ronald Lewis, M.D., Chair
Panel A

XAVIER BECERRA
Attorney General of California
JUDITH T. ALVARADO
Supervising Deputy Attorney General
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Attorneys for Complainant

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the First Amended Accusation Against: ISIDORE KOFI-BREKYI KWAW, M.D. 9201 SUNSET BLVD # 705 LOS ANGELES , CA 90069 Physician's and Surgeon's Certificate No. G 66583, Respondent.	Case Nos. 800-2014-010068 800-2015-012752 OAH Case No. 2018010624 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-entitled proceedings that the following matters are true:

PARTIES

1. Kimberly Kirchmeyer (Complainant) is the Executive Director of the Medical Board of California (Board). She brought this action solely in her official capacity and is represented in this matter by Xavier Becerra, Attorney General of the State of California, by Randall R. Murphy, Deputy Attorney General.

2. Respondent Isidore Kofi-Brekyi Kwaw, M.D. (Respondent) is represented in this proceeding by attorney Thomas R. Bradford, Esq., whose address is: 100 North First Street, Suite 300, Burbank, CA 91502-1845.

3. On or about August 7, 1989, the Board issued Physician's and Surgeon's Certificate No. G 66583 to Isidore Kofi-Brekyi Kwaw, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in First Amended Accusation No. 800-2014-010068, and will expire on April 30, 2019, unless renewed.

4. On March 9, 2011, Respondent was issued a Public Letter of Reprimand in case number 06-2007-183301, pursuant to section 2233 of the Code, for issuing prescriptions to patients for steroids without a legitimate medical purpose and without a prior medical examination as was noted in medical records, in violation of sections 2238, 2242 and 2266 of the Code.

JURISDICTION

5. First Amended Accusation No. 800-2014-010068 and 800-2015-012752 was filed before the Board, and is currently pending against Respondent. The First Amended Accusation and all other statutorily required documents were properly served on Respondent on November 16, 2017, and the First Amended Accusation and all other statutorily required documents were properly served on Respondent on March 6, 2017. Respondent timely filed his Notice of Defense contesting the Accusation.

6. A copy of the First Amended Accusation Nos. 800-2014-010068 and 800-2015-012752 is attached as Exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

7. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in First Amended Accusation Nos. 800-2014-010068 and 800-2015-012752. Respondent has also carefully read, fully discussed with counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

8. Respondent is fully aware of his legal rights in this matter, including the right to a hearing on the charges and allegations in the First Amended Accusation; the right to confront and cross-examine the witnesses against him; the right to present evidence and to testify on his own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision;

and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

9. Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

CULPABILITY

10. Respondent understands and agrees that the charges and allegations in the First Amended Accusation Nos. 800-2014-010068 and 800-2015-012752, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

11. For the purpose of resolving the First Amended Accusation without the expense and uncertainty of further proceedings, Respondent agrees that, at a hearing, Complainant could establish a factual basis for the charges in the First Amended Accusation, and that Respondent hereby gives up his right to contest those charges.

12. Respondent agrees that if he ever petitions for early termination or modification of probation, or if the Board ever petitions for revocation of probation, all of the charges and allegations contained in First Amended Accusation Nos. 800-2014-010068 and 800-2015-012752 shall be deemed true, correct and fully admitted by respondent for purposes of that proceeding or any other licensing proceeding involving respondent in the State of California.

13. Respondent agrees that his Physician's and Surgeon's Certificate is subject to discipline and he agrees to be bound by the Board's probationary terms as set forth in the Disciplinary Order below.

CONTINGENCY

14. This stipulation shall be subject to approval by the Medical Board of California. Respondent understands and agrees that counsel for Complainant and the staff of the Medical Board of California may communicate directly with the Board regarding this stipulation and settlement, without notice to or participation by Respondent or his counsel. By signing the stipulation, Respondent understands and agrees that he may not withdraw his agreement or seek to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails to adopt this stipulation as its Decision and Order, the Stipulated Settlement and Disciplinary

Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal action between the parties, and the Board shall not be disqualified from further action by having considered this matter.

15. The parties understand and agree that Portable Document Format (PDF) and facsimile copies of this Stipulated Settlement and Disciplinary Order, including PDF and facsimile signatures thereto, shall have the same force and effect as the originals.

16. In consideration of the foregoing admissions and stipulations, the parties agree that the Board may, without further notice or formal proceeding, issue and enter the following Disciplinary Order:

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. G 66583 issued to Respondent Isidore Kofi-Brekyi Kwaw, M.D. is revoked. However, the revocation is stayed and Respondent is placed on probation for four (4) years on the following terms and conditions.

1. PRESCRIBING PRACTICES COURSE. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in prescribing practices approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The prescribing practices course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A prescribing practices course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its

designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

2. MEDICAL RECORD KEEPING COURSE. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in medical record keeping approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The medical record keeping course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A medical record keeping course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

3. CLINICAL COMPETENCE ASSESSMENT PROGRAM. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a clinical competence assessment program approved in advance by the Board or its designee. Respondent shall successfully complete the program not later than six (6) months after Respondent's initial enrollment unless the Board or its designee agrees in writing to an extension of that time.

The program shall consist of a comprehensive assessment of Respondent's physical and mental health and the six general domains of clinical competence as defined by the Accreditation Council on Graduate Medical Education and American Board of Medical Specialties pertaining to Respondent's current or intended area of practice. The program shall take into account data

obtained from the pre-assessment, self-report forms and interview, and the Decision(s), Accusation(s), and any other information that the Board or its designee deems relevant. The program shall require Respondent's on-site participation for a minimum of three (3) and no more than five (5) days as determined by the program for the assessment and clinical education evaluation. Respondent shall pay all expenses associated with the clinical competence assessment program.

At the end of the evaluation, the program will submit a report to the Board or its designee which unequivocally states whether the Respondent has demonstrated the ability to practice safely and independently. Based on Respondent's performance on the clinical competence assessment, the program will advise the Board or its designee of its recommendation(s) for the scope and length of any additional educational or clinical training, evaluation or treatment for any medical condition or psychological condition, or anything else affecting Respondent's practice of medicine. Respondent shall comply with the program's recommendations.

Determination as to whether Respondent successfully completed the clinical competence assessment program is solely within the program's jurisdiction.

If Respondent fails to enroll, participate in, or successfully complete the clinical competence assessment program within the designated time period, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. The Respondent shall not resume the practice of medicine until enrollment or participation in the outstanding portions of the clinical competence assessment program have been completed. If the Respondent did not successfully complete the clinical competence assessment program, the Respondent shall not resume the practice of medicine until a final decision has been rendered on the accusation and/or a petition to revoke probation. The cessation of practice shall not apply to the reduction of the probationary time period.

Within 60 days after Respondent has successfully completed the clinical competence assessment program, Respondent shall participate in a professional enhancement program approved in advance by the Board or its designee, which shall include quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education.

Respondent shall participate in the professional enhancement program at Respondent's expense during the term of probation, or until the Board or its designee determines that further participation is no longer necessary.

4. NOTIFICATION. Within seven (7) days of the effective date of this Decision, the Respondent shall provide a true copy of this Decision and Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to Respondent, at any other facility where Respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to Respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days.

This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

5. SUPERVISION OF PHYSICIAN ASSISTANTS AND ADVANCED PRACTICE NURSES. During probation, Respondent is prohibited from supervising physician assistants and advanced practice nurses. It is understood that Respondent provides part-time physician coverage in three acute care hospital emergency departments that are, at times, concurrently staffed with physician assistants and/or advanced practice nurses who function independently of Respondent and who are individually credentialed, privileged, proctored, and subject to on-going peer review by the Medical Staff pursuant to the Medical Staff Bylaws and who have Delegation of Services Agreements with other duly privileged supervising emergency medicine physicians at these acute care hospitals.

6. OBEY ALL LAWS. Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

7. QUARTERLY DECLARATIONS. Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation.

Respondent shall submit quarterly declarations not later than 10 calendar days after the end

of the preceding quarter.

8. GENERAL PROBATION REQUIREMENTS.

Compliance with Probation Unit

Respondent shall comply with the Board's probation unit.

Address Changes

Respondent shall, at all times, keep the Board informed of Respondent's business and residence addresses, email address (if available), and telephone number. Changes of such addresses shall be immediately communicated in writing to the Board or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021(b).

Place of Practice

Respondent shall not engage in the practice of medicine in Respondent's or patient's place of residence, unless the patient resides in a skilled nursing facility or other similar licensed facility.

License Renewal

Respondent shall maintain a current and renewed California physician's and surgeon's license.

Travel or Residence Outside California

Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) calendar days.

In the event Respondent should leave the State of California to reside or to practice, Respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return.

9. INTERVIEW WITH THE BOARD OR ITS DESIGNEE. Respondent shall be available in person upon request for interviews either at Respondent's place of business or at the probation unit office, with or without prior notice throughout the term of probation.

10. NON-PRACTICE WHILE ON PROBATION. Respondent shall notify the Board or

its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of Respondent's return to practice. Non-practice is defined as any period of time Respondent is not practicing medicine as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. If Respondent resides in California and is considered to be in non-practice, Respondent shall comply with all terms and conditions of probation. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice and does not relieve Respondent from complying with all the terms and conditions of probation. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

In the event Respondent's period of non-practice while on probation exceeds 18 calendar months, Respondent shall successfully complete the Federation of State Medical Boards's Special Purpose Examination, or, at the Board's discretion, a clinical competence assessment program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

Respondent's period of non-practice while on probation shall not exceed two (2) years.

Periods of non-practice will not apply to the reduction of the probationary term.

Periods of non-practice for a Respondent residing outside of California will relieve Respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; General Probation Requirements; Quarterly Declarations; Abstain from the Use of Alcohol and/or Controlled Substances; and Biological Fluid Testing.

11. COMPLETION OF PROBATION. Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, Respondent's certificate shall

be fully restored.

12. VIOLATION OF PROBATION. Failure to fully comply with any term or condition of probation is a violation of probation. If Respondent violates probation in any respect, the Board, after giving Respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against Respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

13. LICENSE SURRENDER. Following the effective date of this Decision, if Respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, Respondent may request to surrender his or her license. The Board reserves the right to evaluate Respondent's request and to exercise its discretion in determining whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, Respondent shall within 15 calendar days deliver Respondent's wallet and wall certificate to the Board or its designee and Respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation. If Respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

14. PROBATION MONITORING COSTS. Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee no later than January 31 of each calendar year.

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Thomas R. Bradford, Esq.. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated

Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: 5/23/18

ISIDORE KOFI-BREKYI KWAW, M.D.
Respondent

I have read and fully discussed with Respondent Isidore Kofi-Brekyi Kwaw, M.D. the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

DATED: 5/23/18

THOMAS R. BRADFORD, ESQ.
Attorney for Respondent

ENDORSEMENT

The foregoing Stipulated Settlement and Disciplinary Order is hereby respectfully submitted for consideration by the Medical Board of California.

Dated:

Respectfully submitted.

XAVIER BECERRA
Attorney General of California
JUDITH T. ALVARADO
Supervising Deputy Attorney General

RANDALL R. MURPHY
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

First Amended Accusation No. 800-2014-010068 and 800-2015-012752

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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the First Amended Accusation Against: Isidore Kofi-Brekyi Kwaw, M.D. 9201 Sunset Blvd., Suite 705 Los Angeles, CA 90069 Physician's and Surgeon's Certificate No. G 66583, Respondent.	Case No. 800-2014-010068 800-2015-012752 **FIRST AMENDED ACCUSATION**

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer (Complainant) brings this First Amended Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about August 7, 1989, the Medical Board issued Physician's and Surgeon's Certificate Number G 66583 to Isidore Kofi-Brekyi Kwaw, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on April 30, 2019, unless renewed.

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JURISDICTION

3. This First Amended Accusation is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. The Medical Practice Act (Act) is codified at sections 2000 et seq., of the Business and Professions Code.

5. Pursuant to Code section 2001.1, the Board's highest priority is public protection.

6. Section 2004 of the Code states:

"The board shall have the responsibility for the following:

"(a) The enforcement of the disciplinary and criminal provisions of the Medical Practice Act.

"(b) The administration and hearing of disciplinary actions.

"(c) Carrying out disciplinary actions appropriate to findings made by a panel or an administrative law judge.

"(d) Suspending, revoking, or otherwise limiting certificates after the conclusion of disciplinary actions.

"(e) Reviewing the quality of medical practice carried out by physician and surgeon certificate holders under the jurisdiction of the board.

"..."

7. Section 2234 of the Code, states:

"The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

"(b) Gross negligence.

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from

the applicable standard of care shall constitute repeated negligent acts.

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

"(d) Incompetence.

"(e) The commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and surgeon.

"(f) Any action or conduct which would have warranted the denial of a certificate.

"(g) The practice of medicine from this state into another state or country without meeting the legal requirements of that state or country for the practice of medicine. Section 2314 shall not apply to this subdivision. This subdivision shall become operative upon the implementation of the proposed registration program described in Section 2052.5.

"(h) The repeated failure by a certificate holder, in the absence of good cause, to attend and participate in an interview by the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board."

8. Section 2266 of the Code states: "The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

FACTS

Patient N.M.[1]

9. N.M. was admitted to Memorial Hospital of Gardena on November 20, 2013, after he went into acute respiratory distress during a hemodialysis treatment. He had been discharged the previous day from another hospital (Little Company of Mary) after a week-long stay for sepsis.

[1] Initials are used to protect patient privacy.

10. Paramedics transported N.M. to the emergency department at Gardena, where he was immediately intubated for acute respiratory distress and agonal[2] respirations. He was placed on a cardiac monitor and, after an initial workup, including labs and chest x-rays, he was transported to the intensive care unit (ICU) on antibiotics and "pressors"[3] to support his low blood pressure. The emergency department admission notes state that "the patient's code status was verified to be "full code."[4]

11. On November 21, 2013, at 4:55 a.m., N.M. went into cardiac arrest and a Code Blue[5] was initiated. Respondent was the emergency physician on duty and was paged to run the code.

12. The Code Blue Record indicates that the first epinephrine bolus[6] was administered at 4:55 a.m., the same time the code was started. The second epinephrine bolus was delivered at 5:00 a.m., at which time CPR was initiated and a pulse check done. No further treatments were given, and the code was stopped at 5:01 a.m., with N.M.'s disposition checked as "expired."

13. Respondent acknowledged that he had not been very "aggressive" and had ended this code after the second dose of epinephrine because he determined that he would not have been able to "do anything for the patient." He stated that he reached this conclusion based on the information given to him by the nursing staff, as well as the fact that N.M. was on full pressors with a blood pressure of 40/palp.[7]

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[2] Agonal respiration is an abnormal breathing pattern.

[3] A "pressor" is an antihypotensive agent, also known as a vasopressor agent and is any medication that tends to raise reduced blood pressure. Some antihypotensive drugs act as vasoconstrictors to increase total peripheral resistance, others sensitize adrenoreceptors to catecholamines, such as glucocorticoids and the third class increase cardiac output, such as dopamine, dobutamine.

[4] In this context "full code" means that resuscitation efforts were to be provided to revive N.M.

[5] In this context "Code Blue" means that the patient needed to be revived and full resuscitation efforts were undertaken.

[6] Epinephrine bolus means administration of Epinephrine in the form of a single, large dose. Epinephrine, also known as adrenalin or adrenaline, is a hormone, neurotransmitter and medication. Epinephrine is normally produced by both the adrenal glands and certain neurons. It plays an important role in the fight-or-flight response by increasing blood flow to muscles, output of the heart, pupil dilation, and blood sugar. It does this by binding to alpha and beta receptors. It is found in many animals and some one cell organisms.

[7] This is a very low blood pressure.

14. The records indicate that Respondent was aware of N.M.'s case for a very short time and without reviewing his chart unilaterally decided not to administer any aggressive resuscitation efforts because Respondent felt it would not have been beneficial. The code was terminated after six minutes without involving N.M.'s family in the decision-making process.

Patient R.S.:

15. Respondent first saw R.S., a 57-year old male, on June 16, 2011, shortly after hospitalization for an acute myocardial infarction that resulted in stenting of his right coronary artery.

16. Respondent next saw R.S. on June 23, 2011, when he presented complaining of anxiety. R.S. reported using Xanax,[8] but received a prescription for Klonopin[9] from Respondent.

17. On May 28, 2013, R.S. presented with complaints of left shoulder and left lower back pain. In the history of present illness in the medical records Respondent states, "He takes Vicodin for pain," although it had not previously appeared in R.S.'s medication list. R.S. was diagnosed with "sprain and strain of other specified sites of shoulder and upper arm" and prescribed a quantity of 60 Vicodin tablets.

18. On August 8, 2013, R.S. returned complaining of pain in his upper and lower back, hip, and neck. A physical examination revealed paravertebral tenderness and decreased range of motion due to pain. Respondent diagnosed lumbago and prescribed 60 Norco[10] tablets.

19. On November 5, 2013, R.S. presented requesting refills of pain medication and Klonopin. No abnormal findings were noted on the examination, and R.S. received a prescription for 90 Lortab[11] pills as well as 60 clonazepam.[12]

20. R.S. next came to Respondent's office on January 28, 2014, again requesting medication refills and complaining of lower back pain. Again, the documented examination is

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[8] Xanax is a trademark for a preparation of alprazolam, an antianxiety agent.

[9] Klonopin is a trademark for a preparation of clonazepam, an anticonvulsant and anti-panic agent.

[10] Norco is an analgesic formulation of acetaminophen and hydrocodone for pain.

[11] Lortab is another name for hydrocodone a semisynthetic opioid analgesic similar to but more active than codeine, used as the bitartrate salt or polistirex complex as an analgesic and antitussive.

[12] Clonazepam is also known as Klonopin.

normal, and R.S. was prescribed another 90 Norco tablets.

21. On March 25, 2014, R.S. presented 10 days after a motor vehicle accident complaining of left shoulder pain, which he stated was fractured. Respondent noted that the left shoulder was moderately tender to palpation, and he diagnosed "crushing injury of shoulder region-with fracture." No indication that R.S. was previously evaluated for the injury or had x-rays taken to diagnose a fracture. Respondent stated that he thought the patient had been seen in the emergency room. Respondent refilled the Norco #60 and Klonopin prescriptions with no further plan documented.

22. R.S. next came to the office on May 13, 2014, for medication refills. R.S. had no complaints and his examination was normal. He was nonetheless given refills for Norco #90 and clonazepam #60.

23. On July 22, 2014, R.S. returned to Respondent complaining of persistent low back pain since his accident causing difficulty with ambulation. The examination is documented the same way it was in 2013, stating: "positive for paravertebral tenderness and decreased range of motion due to pain." Respondent prescribed a higher dose of Norco, but only 30 tablets, and Respondent noted that he would consider physical therapy. The records do not reflect a referral to physical therapy.

24. R.S.'s next visit occurred on October 22, 2014, with complaints of "left hip pain from arthritis," stating he had run out of his pain medications. The examination revealed the left hip to be slightly tender to palpation and Respondent diagnosed "enthesopathy of hip region." Rather than refilling the hydrocodone prescription, R.S. was given 30 tablets of Tylenol w/codeine #3. However, the Klonopin prescription was refilled as well. When asked about this at a Medical Board interview, Respondent stated that he thought he must have had a discussion with R.S. and was concerned about Norco's addictive potential so he decided to go with Tylenol w/codeine instead. Respondent stated that "I didn't feel comfortable giving him any more Norco."

25. R.S. returned to Respondent's office on June 17, 2015, asking to switch from Tylenol #3 to Norco because the Tylenol was too strong. He was given a prescription for low-dose Norco.

26. R.S.'s medical records include one set of laboratory work on May 5, 2012, comprised of a CBC, complete metabolic panel, lipid panel, hemoglobin A1C, and PSA.

27. Subsequent to the initial encounter, R.S.'s coronary artery disease was never addressed again. In addition, it is noted that the review of systems in Respondent's notes frequently contradict R.S.'s chief complaint, the history of present illness, and/or physical examination results.

28. Respondent stated in a Medical Board interview that these contradictions in the records were the result of his electronic medical record process. He was asked about the extensive exams that were charted on many visits, and he replied that he is very thorough and performed most of what was documented.

29. Respondent's records do not reflect an adequate history to support the use of controlled substances, nor a substantiation of any of R.S.'s subjective pain complaints with objective evidence such as imaging or past medical records.

30. Respondent's records do not reflect treatment objectives, but appear to indicate repeated opioid analgesics refilled when requested at office visits by R.S. At no time was the patient given a referral for physical therapy.

31. Respondent's records do not reflect documentation indicating that Respondent discussed the potential side effects of the controlled substances he prescribed to R.S.

32. Respondent's records do not reflect any structured treatment plan or objectives in place for R.S. and no documentation of R.S.'s progress toward treatment goals, or lack thereof, are contained in the records. In lieu of a comprehensive treatment plan, medications were simply refilled upon request based on complaints of pain or anxiety.

33. Respondent's records indicate that R.S.'s pain did not appear to be excessive or complex, but no mention of orthopedic care was documented after the patient suffered a shoulder fracture as a result of motor vehicle accident.

34. Respondent's records contain ubiquitous contradictions between history, a review of systems and physical examination results that may stem from use of the "all normal" function in

Respondent's electronic medical record keeping system making it difficult to ascertain what actually took place at any given office visit.

Patient J.A.:

35. Respondent first saw J.A., a 33-year-old woman, on December 26, 2011, when she presented with a sore throat. No past medical history was charted at that time.

36. On June 7, 2012, J.A. came in for a refill of her Klonopin. Again, her past medical history is not documented. Respondent stated in his Medical Board interview that he thought J.A. had brought in bottles from previous prescriptions provided by her psychiatrist. In the psychiatric section of the review of systems, Respondent stated that the patient "denies hx of depression, anxiety, or suicidal tendencies." No physical examination was performed, however, a prescription for Klonopin was provided.

37. On November 12, 2012, J.A. presented complaining of insomnia. She was seen by Respondent's physician assistant, who noted that J.A. had been taking both Ambien and Klonopin together to help her sleep. The records indicate an impression of "insomnia (unspecified)" and a recommendation by the physician assistant not to prescribe J.A. Ambien, but instead to refer J.A. to a psychiatrist. J.A. was also advised not to mix medications. In his interview, Respondent was asked if a discussion was held about J.A.'s sleep hygiene, but Respondent responded that he did not understand what was meant by that term.

38. Respondent next saw J.S. on November 4, 2013, when J.A. came in requesting prescriptions for Prozac and Klonopin. There is no documentation in the medical records of a history, physical examination, review of systems, assessment, or plan. Respondent provided prescriptions for both medications.

39. On November 25, 2013, J.A. returned to the office stating that Klonopin was not helping her sleep. The recently prescribed Prozac did not appear on the medication list, and the records are unclear as to whether or not she was taking the Prozac. J.A. was diagnosed with "insomnia due to medical condition" (an inaccurate code according to Respondent) and then

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prescribed trazodone.[13]

40. On January 27, 2014, J.A. returned to Respondent complaining of lower back pain and requesting a refill on her Adderall.[14] Respondent stated that he believed J.A. had been diagnosed with ADHD by a psychiatrist, but he had no notes reflecting that belief from psychiatry. J.A. was diagnosed with lumbago, but the only actions taken in the recommendations were to send urine for culture (patient had expressed concern over possibly having a urinary tract infection), and to refill the Adderall as requested.

41. At his interview with the Medical Board Respondent stated that when patients came in with empty prescription bottles that need a refill, he did not necessarily take a history.

42. On March 3, 2014, J.A. returned to the office to see the physician assistant for an Adderall refill, which was provided without any history or exam.

43. On April 19, 2014, J.A. again returned to the office to see the physician assistant for an Adderall refill, which was provided without any history or exam, although J.A. was "educated about complications from the abuse of stimulants like Adderall. Prescriptions for Klonopin and Prozac were both refilled.

44. On June 3, 2014, J.A. again returned to the office complaining of lower back pain resulting from "swimming in the Amazon." The physical examination noted J.A. to be "positive for paravertebral tenderness and decreased range of motion due to pain." J.A. was diagnosed with lumbago and prescribed Norco.

45. On July 22, 2014, J.A. again returned to the office requesting an Adderall refill and was given refills for Klonopin, Norco, and Prozac as well, in addition to the Adderall. The Norco prescription was for twice the quantity as the previous visit; however, there is no discussion of her pain in the medical records.

46. J.A. returned to the office requesting an Adderall refill on September 13, 2014,

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[13] Trazodone (sold under the brand name Oleptro, among many others) is an antidepressant of the serotonin antagonist and reuptake inhibitor (SARI) class. It is a phenylpiperazine compound. Trazodone also has anti-anxiety (anxiolytic) and sleep-inducing (hypnotic) effects.

[14] Adderall is a trademark for a drug containing a combination of amphetamine and dextroamphetamine salts.

October 31, 2014, May 7, 2015, July 8, 2015, August 27, 2015, October 29, 2015, November 18, 2015, March 30, 2016, April 27, 2016, May 31, 2016 and July 14, 2016. The medical records for each of these visits have an identical subjective section, stating that the patient "has a normal blood pressure today" and that she "has been educated about the complications of the abuse of stimulants like Adderall, one being: sudden cardiac death."

47. Respondent never took a history surrounding J.A.'s use of Klonopin or Adderall, nor was there any assessment of J.A.'s psychological function. The medical records indicate that J.A. was given refill prescriptions for these medications purely on the basis of her having told Respondent that she was already taking them.

Patient J.2A.:

48. Respondent first saw J.2A., a 54-year-old woman, on December 12, 2002, when she presented with low back pain. The progress note from this visit lists narcolepsy as one of her chronic conditions, and Xyrem[15] as one of her current medications.

49. Respondent next saw J.2A. on April 1, 2003, when she discussed her narcolepsy with Respondent, whose records indicate she had taken Xyrem "from time to time in the past" and that it had been prescribed by her psychiatrist. Respondent took over the prescribing of Xyrem, although he admitted that he had no documentation from anyone that J.2A. had a diagnosis of narcolepsy, and he admitted that he was prescribing J.2A. the medication based solely on her word that she needed it. Respondent admitted that he was not aware that Xyrem is a restricted medication and he described it as a Schedule 2 central nervous system stimulant that might be a monoamine oxidase inhibitor. He admitted he had not studied the drug extensively.

50. Respondent's medical records do not indicate that he diagnosed J.2A. with narcolepsy and do not show any documentation that another practitioner made that diagnosis. No history of J.2A. established the diagnosis other than a mention that J.2A. was doing well on the medication and "does not have any more day time sleeping."

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[15] Xyrem is used in the treatment of cataplexy in patients with narcolepsy (generally with concurrent stimulant therapy).

51. Respondent's notes indicate no measures of the Xyrem treatment's effectiveness other than that J.2A. "continues to do well", but there are no other measures of the treatment's effectiveness beyond the patient's subjective report.

52. Respondent's notes indicate that he did not initiate the Xyrem prescription, but he did write ongoing refills without a clear understanding of the drug or the disease state.

Patient M.B.:

53. Respondent first saw M.B., a 32-year-old woman, on August 28, 2012, when she presented stating that she had recently moved to the area, had no doctor yet, and needed a refill for Adderall. Respondent's notes indicate that M.B.'s past medical history was significant only for "scarring on her esophagus." No further history regarding the need for Adderall is in the records, and there is no diagnosis documented that would require a prescription for Adderall. Respondent stated that M.B. had a diagnosis of ADHD and must have shown him an Adderall pill bottle provided by a psychiatrist previously seen. M.B. was prescribed Adderall XR 30 mg daily and Adderall 15 mg BID.

54. Respondent next saw M.B. on October 16, 2012, when she came to the office for an Adderall refill and also requested Nexium[16] for a history of GERD. A Nexium prescription was provided, with no discussion of the patient's reported esophageal scarring. Adderall was also refilled, but this time the dosages were Adderall XR 30 mg daily and Adderall 20 mg once daily.

55. Respondent next saw M.B. on December 21, 2012, when the Adderall was refilled but the 20 mg pills were increased to BID.

56. Respondent saw M.B. monthly thereafter for Adderall refills, but on December 16, 2013, Respondent's notes indicate that the "[p]atient has also been under a lot of stress" and he prescribed Klonopin. No history taken to characterize the stress, and no diagnosis is charted in the medical records.

57. Respondent next saw M.B. on February 1, 2014, when she presented with complaints of depression, in addition to wanting an Adderall refill. The physical examination stated that she

[16] Nexium reduces gastric acid production by inhibiting enzyme activity in gastric parietal cells, preventing transport of hydrogen ions into gastric lumen.

had "No depression, anxiety or agitation" yet she was diagnosed with reactive depression. Adderall refills were again provided on this visit and on February 21, 2014 and March 3, 2014.

58. Respondent's notes indicate that he did not diagnose M.B. with ADHD nor did he have any documentation that another practitioner had made that diagnosis. There is no history to establish the diagnosis other than M.B.'s claim.

59. Respondent's notes indicate that he did not develop a treatment plan or objectives for M.B. yet he continued to prescribe controlled substances to her.

60. Respondent's notes indicate that he did not question M.B. about the state of her ADHD or how the medication was working and it was occasionally reflected in the medical records that M.B. was having her medication adjusted by a psychiatrist back east, as well.

61. Respondent's notes indicate that he did not initiate the Adderall prescription for M.B., but he did write ongoing refills and did not refer M.B. to a local psychiatrist for specialist care when she developed symptoms of anxiety and depression.

62. Respondent's notes indicate that he did not document a history or physical examination beyond vital signs for M.B. and in several of the medical records information in the RPI, exam, and review of systems contradict each other.

63. Respondent's notes indicate that he did undertake a history or physical examination in response to M.B.'s report of increased stress or depression and he did not question her about suicide. Neither do Respondent's notes indicate that he considered that M.B.'s depression could be a side effect of the benzodiazepine he had recently prescribed.

Patient T.B.:

64. T.B. is a 54-year-old woman who used to work with Respondent in an emergency room in her capacity as a respiratory therapist. From 2009 to 2013, Respondent wrote prescriptions for phentermine for T.B. for weight loss despite the fact she was not his patient and he kept no medical records on her. Respondent stated during an interview with the Medical Board that he never made a medical record for T.B. because she never came to his office.

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FIRST CAUSE FOR DISCIPLINE

(Unprofessional conduct-gross negligence)

65. Respondent is subject to disciplinary action under section 2234, subdivision (b), in that he engaged in unprofessional conduct constituting gross negligence. The circumstances are as follows:

66. Paragraphs 9 through 64 are included herein by reference.

67. On or about November 21, 2014, Respondent, failed to provide appropriate resuscitation efforts to N.M. resulting in his death, which constitutes gross negligence.

68. Respondent, failed to obtain a proper history, perform an examination, and establish an indication for the use of controlled substances for J.A., which constitutes gross negligence.

69. Respondent prescribed a controlled substance for T.B. while keeping no medical records on her, not monitoring her vital signs while prescribing her a stimulant medication, and not keeping track of her weight despite giving her a weight loss medication, which constitutes gross negligence.

SECOND CAUSE FOR DISCIPLINE

(Unprofessional conduct-repeated negligent acts)

70. Respondent is subject to disciplinary action under section 2234, subdivision (c), in that he engaged in unprofessional conduct constituting repeated negligent acts. The circumstances are as follows:

71. Paragraphs 9 through 69 are included herein by reference.

72. Respondent failed to document an appropriate history and establish a compelling indication for the use of controlled substances for R.S., which constitutes a negligent act.

73. Respondent failed to outline a treatment plan or vary treatment modalities despite repeat office visits for the same complaints for R.S., which constitutes a negligent act.

74. Respondent failed to discuss the potential side effects of the controlled substances he prescribed to R.S. thus failing to obtain informed consent from R.S., which constitutes a negligent act.

75. Respondent failed to make an appropriate referral after a traumatic injury to R.S.,

which constitutes a negligent act.

76. Respondent failed to formulate a treatment plan surrounding the use of controlled substances for patient J.A., which constitutes a negligent act.

77. Respondent failed to discuss potential side effects of Adderall (and stimulants in general) or about the ongoing use of Klonopin, and/or Norco with J.A., thus no informed consent was obtained from J.A., which constitutes a negligent act.

78. Respondent failed to determine if the prescribed medications were working for J.A., but simply refilled them upon request and failed to periodically review the course of treatment for J.A., which constitutes a negligent act.

79. Respondent failed to diagnose J.2A. with narcolepsy, did not have any documentation that another practitioner had made that diagnosis and had no history to establish the diagnosis, nor had any other justification for prescribing a controlled substance, which constitutes a negligent act.

80. Respondent failed to document a treatment plan or objectives for J.2A., which constitutes a negligent act.

81. Respondent failed to discuss potential side effects of Xyrem with J.2A. thus no informed consent was obtained from J.2A., which constitutes a negligent act.

82. Respondent failed to return J.2A. to the care of a psychiatrist, sleep specialist, or other practitioner certified to prescribe Xyrem, which constitutes a negligent act.

83. Respondent failed to document an appropriate history or physical examination to substantiate the use of controlled substances for M.B., which constitutes a negligent act.

84. Respondent failed to document a treatment plan or objectives for M.B., which constitutes a negligent act.

85. Respondent failed to periodically review the course of treatment for M.B. and failed to monitor her progress, which constitutes a negligent act.

86. Respondent failed to refer M.B. to a local psychiatrist for specialist care when she developed symptoms of anxiety and depression, which constitutes a negligent act.

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THIRD CAUSE FOR DISCIPLINE

(Failure to maintain adequate and accurate medical records)

87. Respondent is subject to disciplinary action under Code section 2266 in that he failed to maintain adequate and accurate medical records. The circumstances are as follows:

88. Paragraphs 9 through 86 are included herein by reference.

89. Respondent failed to document an appropriate history, a compelling indication for the use of controlled substances or outline a treatment plan for R.S., which constitutes a failure to maintain adequate and accurate medical records for R.S.

90. Respondent failed to document an appropriate history and physical examination for J.A. and the assessments do not always follow logically from the subjective and objective information presented earlier in the specific medical records, which constitutes a failure to maintain accurate and adequate medical records for J.A.

91. Respondent failed to document a history or physical examination beyond vital signs for M.B. and in several of the medical records information in the RPI, exam, and review of systems contradict each other, which constitutes a failure to maintain accurate and adequate medical records for M.B.

92. Respondent failed to keep any medical records for T.B., which constitutes a failure to maintain accurate and adequate medical records for T.B.

FOURTH CAUSE FOR DISCIPLINE

(Unprofessional conduct-incompetence)

93. Respondent is subject to disciplinary action under section 2234, subdivision (d) in that he engaged in unprofessional conduct constituting incompetence. The circumstances are as follows:

94. Paragraphs 9 through 92 are included herein by reference.

95. Respondent failed to obtain a history for J.A. regarding her insomnia except to note that her husband snored, so she had difficulty sleeping. Nevertheless, J.A. was given numerous different medications including Ambien, Klonopin, and trazodone without ever elucidating the etiology of the insomnia. When asked about sleep hygiene during his interview, Respondent was

not familiar with the term, which evidences a lack of knowledge regarding diagnosis and treatment of insomnia, constituting incompetence.

96. Respondent mistakenly categorized Xyrem as a Schedule 2 CNS stimulant, when in fact it is a Schedule 3 CNS depressant. This error could have affected his ability to monitor the patient for potential problems related to treatment, which evidences a lack of knowledge regarding diagnosis and treatment of insomnia, constituting incompetence.

97. Respondent's notes indicate that he did not undertake a history or physical examination in response to M.B.'s report of increased stress or depression and he did not question her about suicide. Neither do Respondent's notes indicate that he considered that M.B.'s depression could be a side effect of the benzodiazepine he had recently prescribed, which evidences a lack of knowledge regarding diagnosis and management of anxiety and depression, constituting incompetence.

DISCIPLINARY CONSIDERATIONS

98. On March 9, 2011, Respondent was issued a Public Letter of Reprimand in case number 06-2007-183301, pursuant to section 2233 of the Code, for issuing prescriptions to patients for steroids without a legitimate medical purpose and without a prior medical examination as was noted in medical records, in violation of sections 2238, 2242 and 2266 of the Code.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate Number G 66583, issued to Isidore Kofi-Brekyi Kwaw, M.D.;

2. Revoking, suspending or denying approval of his authority to supervise physician assistants and advanced practice nurses;

3. Ordering Isidore Kofi-Brekyi Kwaw, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

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4. Taking such other and further action as deemed necessary and proper.

DATED: March 15, 2018

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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